

Commonwealth **INDEMNITY PLAN**

**For Retired Municipal Teachers
& Elderly Government Retirees**
Benefit Updates and Important Information



SERIES 3
EFFECTIVE
JULY 1, 2006

Updates to the Commonwealth Indemnity Plan Member Handbook

This booklet contains important updates to your Commonwealth Indemnity Plan coverage, effective July 1, 2006. Please keep this year's benefit update—together with the Series 3 Member Handbook and the 2004 and 2005 Series 3 benefit updates—in a convenient place for easy access when you need to refer to your health plan information.

If you have any questions about these changes, please call the Commonwealth Service Center at **(800) 442-9300**, Monday through Thursday from 8:30 a.m. to 6:00 p.m., and Friday from 8:30 a.m. to 5:00 p.m. If you are deaf or hard of hearing and have a TDD machine, contact us on our TDD lines at (800) 322-9161 or (978) 474-5163. A customer service representative will be happy to help you.

This benefit update has also been added to the Plan's web site: **www.unicare-cip.com**. This updated information will be included in the next **printed** revision of the Member Handbook.

Note: The page references in this document refer to Member Handbook pages, unless otherwise specified.

Important: Certain changes in this booklet apply only to **non-Medicare eligible** members, some apply only to **Medicare eligible** members and some apply to both. Please look for the following headings to be sure you are reading the information that applies to you:

For Non-Medicare Eligible Members Only

For Medicare Eligible Members Only

For Both Non-Medicare Eligible & Medicare Eligible Members

For Non-Medicare Eligible Members Only

Benefit Changes

Outpatient Surgery

There is now a \$75 quarterly deductible for outpatient surgery. The following changes are made to the Series 3 Member Handbook to reflect the new outpatient surgery deductible:

- A. The chart in Your Costs section on page 8 of the Series 3 Member Handbook is deleted and replaced with the following:**

Deductibles

A deductible is a fixed dollar amount you pay for certain services before the Plan begins paying benefits for you or for a covered dependent. The deductible amounts you must satisfy are shown in the chart below.

Deductibles	Coverage Without CIC (non-comprehensive coverage)	Coverage With CIC (comprehensive coverage)
Individual Calendar Year Deductible	\$100	\$75
Family Calendar Year Deductible	\$200	\$150
Inpatient Hospital Quarterly Deductible (per person)	\$250	\$150
Outpatient Surgery Quarterly Deductible (per person)	\$75	\$75



B. The following text is added to the Your Costs section on pages 8-9 of the Series 3 Member Handbook:

Outpatient Surgery Quarterly Deductible

The outpatient surgery quarterly deductible is a per-person, per-calendar year quarter deductible. Each time you or a covered dependent has surgery at a hospital or freestanding surgical facility, you are responsible for paying this deductible. However, once a covered person satisfies the outpatient surgery quarterly deductible in any calendar year quarter, he or she will not have to satisfy this deductible again during that same calendar year quarter. This deductible does not apply toward the individual calendar year deductible.

For example: If you have outpatient surgery at a hospital in January, you will be responsible for paying the \$75 deductible on the hospital charges. If you have another surgery in March, you will not have to pay another deductible as March is in the same calendar year quarter as January. However, if you have surgery at a hospital in May, you will incur another \$75 deductible.

C. The coverage for surgery in the Benefit Highlights section on page 28 of the Series 3 Member Handbook is deleted and replaced with the following:

Without CIC		With CIC
 Surgery		 Also see page 67
Inpatient Surgery	80%	100%
Outpatient Surgery	80% after the outpatient surgery quarterly deductible	100% after the outpatient surgery quarterly deductible

Family Calendar Year Deductible

The text under “Family Calendar Year Deductible” in the Your Costs section on page 9 of the Series 3 Member Handbook is deleted and replaced with the following:

Family Calendar Year Deductible

If you have family coverage with CIC, \$150 in deductibles will apply to your family in any calendar year. If you have family coverage without CIC, your family will be responsible for paying \$200 in deductibles in any calendar year.

For Example: You, your spouse and three children have family coverage with CIC. You and two of your children go to a provider for medical care in January. Each of you pay \$50 in deductibles. Even though no one in the family has met the \$75 individual deductible, because the family deductible of \$150 has been met, no additional calendar year deductible will apply to charges for your family.

Copayments

The 15 office visit copayment maximum has been eliminated; all office visits are now subject to a copayment. The following changes are made to the Series 3 Member Handbook to reflect the change to the 15 office visit copayment maximum:

A. The subsection “Copayments” in the Your Costs section on page 9 of the Series 3 Member Handbook is deleted and replaced with the following:



Copayments

A copayment (“copay”) is a fixed dollar amount you pay to a provider at the time of service. Copay amounts vary depending on the type of service you receive. Copays are always deducted before the individual calendar year deductible is applied. Copayments do not count toward satisfying deductibles, coinsurance amounts or out-of-pocket maximums.

For example: If you are a member in the Commonwealth Indemnity Plan with CIC and you or a covered dependent go to a physician’s or chiropractor’s office, you or your dependent will pay a \$10 copay at the time of the visit. Although you usually pay the copay at the time of the visit, you can also wait until the provider bills you.

Another example of a copay you may owe is the \$50 copay every time you go to the emergency room. This copay is waived if you are admitted to the hospital. However, if you are admitted to the hospital, the inpatient hospital quarterly deductible applies.


B. The coverage for physician services in the Benefit Highlights section on page 30 of the Series 3 Member Handbook is deleted and replaced with the following:

Without CIC		With CIC
Physician Services		 Also see page 71
Non-Emergency Treatment at Home, Office or Outpatient Hospital	80% after a \$10 copay per visit and after the calendar year deductible. The copay does not count toward the calendar year deductible or the out-of-pocket maximum.	100% after a \$10 copay per visit and after the calendar year deductible. The copay does not count toward the calendar year deductible or the out-of-pocket maximum.
Hospital Inpatient	80%	100%
Emergency Treatment	80%	100%
 Chiropractic Care or Treatment	80% after a \$10 copay per visit and after the calendar year deductible; maximum benefit of \$40 per visit, 20 visits per calendar year. The copay and the 20% coinsurance amount do not count toward the calendar year deductible or the out-of-pocket maximum.	80% after a \$10 copay per visit and after the calendar year deductible; maximum benefit of \$40 per visit, 20 visits per calendar year. The copay and the 20% coinsurance amount do not count toward the calendar year deductible or the out-of-pocket maximum.

C. Footnote 1 in the Benefit Highlights section on page 30 of the Series 3 Member Handbook is deleted.

Other Inpatient Facilities

The coverage for other inpatient facilities on page 27 of the Benefit Highlights section of the Series 3 Member Handbook is deleted and replaced with the following:


Without CIC		With CIC
Other Inpatient Facilities		 Also see page 66
<ul style="list-style-type: none"> • Sub-acute Care Hospital/Facility • Transitional Care Hospital/Facility • Long-term Care Hospital/Facility • Chronic Disease Hospital/Facility • Skilled Nursing Facility 	<p>80% after the calendar year deductible, up to a maximum of 45 days per calendar year</p> <p>The 20% coinsurance amount does not count toward the out-of-pocket maximum</p>	<p>80% after the calendar year deductible, up to a maximum of 45 days per calendar year</p> <p>The 20% coinsurance amount does not count toward the out-of-pocket maximum</p>

Benefit Clarifications

Preventive Care

The chart describing the coverage for preventive care is changed to include the benefit for preventive care laboratory services. The following changes are made to the Benefit Highlights section on page 31 of the Series 3 Member Handbook:

A. The coverage for preventive care in the Benefit Highlights section on page 31 of the Series 3 Member Handbook is deleted and replaced with the following:

	Without CIC	With CIC
Preventive Care		 Also see page 72
Office Visits <i>(refer to frequency limits on page 72)</i>	100% after a \$10 copay per visit. The copay does not count toward the calendar year deductible or the out-of-pocket maximum.	100% after a \$10 copay per visit. The copay does not count toward the calendar year deductible or the out-of-pocket maximum.
Annual Gynecological Visits	100% after a \$10 copay per visit. The copay does not count toward the calendar year deductible or the out-of-pocket maximum.	100% after a \$10 copay per visit. The copay does not count toward the calendar year deductible or the out-of-pocket maximum.
Immunizations	100%	100%
Laboratory Testing ³ <i>(performed by Preferred Vendors or Other Contracted Providers¹)</i>	100%	100%
Laboratory Testing ³ <i>(performed by other providers)</i>	80% ⁴ . The 20% coinsurance amount does not count toward the out-of-pocket maximum.	80% ⁴ . The 20% coinsurance amount does not count toward the out-of-pocket maximum.

B. The following footnotes are added to the Benefit Highlights section on page 31 of the Series 3 Member Handbook:

- ³ For information on covered preventive laboratory services, see the preventive care schedule on page 72.
- ⁴ Enrollees residing or traveling outside of New England will receive 100 percent of the Reasonable and Customary Allowed Amount for services obtained from any licensed diagnostic laboratory.


For Medicare Eligible Members Only

Benefit Clarifications

Preventive Care

The coverage for preventive care in the Benefit Highlights section on page 61 of the Series 3 Member Handbook is deleted and replaced with the following:

- A. The coverage for preventive care in the Benefit Highlights section on page 61 of the Series 3 Member Handbook is deleted and replaced with the following:**

Without CIC		With CIC
Preventive Care		 Also see page 72
Office Visits (refer to frequency limits on page 72)	100% after a \$5 copay per visit. The copay does not count toward the calendar year deductible.	100% after a \$5 copay per visit. The copay does not count toward the calendar year deductible or the out-of-pocket maximum.
Annual Gynecological Visits	100% after a \$5 copay per visit. The copay does not count toward the calendar year deductible.	100% after a \$5 copay per visit. The copay does not count toward the calendar year deductible or the out-of-pocket maximum.
Immunizations	100%	100%
Laboratory Testing	80%	100%

For Both Non-Medicare Eligible and Medicare Eligible Members

Benefit Clarifications

Preventive Care

Item 25(d) in the Description of Covered Services section on page 72 of the Series 3 Member Handbook is modified to add the following:

- Colonoscopy for routine screening (once every 10 years after age 50)

Exclusions

The following items have been added to the Exclusions section on pages 77-79 of the Series 3 Member Handbook:

- Benefits for the diagnosis, treatment or management of mental health/substance abuse conditions by medical (non-mental health) providers. These benefits are covered when provided by mental health providers (see United Behavioral Health section for coverage details).
- Molding helmets

Limitations

Item 12 in the Limitations section on page 81 of the Series 3 Member Handbook is deleted and replaced with the following:

12. Treatment of Temporomandibular Joint (TMJ) disorder is limited to the initial diagnostic examination, initial testing and medically necessary surgery.

Plan Definitions

The following definition is added to the Plan Definitions section on pages 82-88 of the Series 3 Member Handbook:

“Terminal Illness” – an illness, which, if it runs its course, is associated with a life expectancy of six months or less.

General Provisions

The following wording is added to the description of full-time student coverage on page 89 of the General Provisions section of the Series 3 Member Handbook:

The member is responsible for notifying the Plan of any changes in full-time student status.

Important Plan Information

Involuntary Disenrollment Rate

In accordance with Division of Insurance regulations, UniCare reports that its involuntary disenrollment rate among its members for its Massachusetts book of business was 0 percent in 2005.

Do You Have Medical Coverage under Another Health Plan?

If you have medical benefits under another health plan in addition to the Commonwealth Indemnity Plan, you need to let us know by completing our “Other Health Insurance” form. This way, we can work with the other health plan to determine which plan has primary responsibility for providing coverage for each service. (Please note: Enrollment in Medicare is not considered an additional health plan if you are a member of the Medicare Extension Plan.)

This is called “coordination of benefits.” This provision lets members with coverage under another plan use the coverage available to them under all health plans in which they are enrolled.

You must also complete the Other Health Insurance form if any of your **family members** covered under the Commonwealth Indemnity Plan also have medical benefits under another health plan.

Important: You do not have to complete the Other Health Insurance form if you only have health plan coverage under the Commonwealth Indemnity Plan. It is not necessary to tell us about coverage under:

- Medicare (if you are a Medicare Extension Plan member*)
- MassHealth
- TriCare, or
- other types of coverage such as dental, vision or life insurance plans

* If you are enrolled in Medicare Part A or B and are **not** a Medicare Extension Plan member, you need to complete the Other Health Insurance form.

How to Get a Copy of the “Other Health Insurance” Form

- **New Plan Members:** You’ll find a copy of this form in your welcome package.
- **Renewing Plan Members:** You can download this form from our web site at www.unicare-cip.com by clicking on the link for “Other Health Insurance Form” on the Forms and Documents web page. Or call us at (800) 442-9300 to request the form.

Need Help?

If you’re not sure whether you need to complete the Other Health Insurance form, a customer service representative can help you. Please call (800) 442-9300.

Resources Available on the Plan's Web Site

Member access to the Healthwise® Knowledgebase at www.unicare-cip.com, the Plan's web site, has been replaced with access to *WebMD®* Personal Health Manager™. *WebMD®* Personal Health Manager™ provides members with a highly personalized online health experience by bringing together trusted health information, enhanced personalized capabilities and comprehensive health risk assessments—including tracking and reminder tools—to help you better manage your health care and health care decision making. You can tailor the site to your own particular medical background and receive medical information directly related to your conditions and diagnoses. You'll find this resource on our Health Care Resources web page.

The Plan's web site, www.unicare-cip.com, offers you an extensive range of Plan-related and general health care information and resources. These resources give you the ability to:

- Check the status of your claims.
- Find out about member discounts on a variety of health-related products and services.
- Access information to help you understand and manage various health conditions and treatment procedures with the Healthcare Advisor™. This resource also provides profiles of health care facilities to help you assess where to best receive care, based on your needs and preferences.
- Visit *WebMD®* Personal Health Manager™ to help you better manage your health care and health care decision making.
- Learn what's being done to improve patient safety in hospitals and how this information may help you select a hospital. Find out the extent to which hospitals in your area have implemented safety initiatives developed by the Leapfrog Group for Patient Safety and how frequently they have performed certain procedures.
- Access important Plan information, such as notification requirements.
- View your Member Handbook, benefit updates and detailed descriptions of certain Plan benefits.
- Check our list of Preferred Vendors for durable medical equipment and medical supplies.
- Order Plan materials, e-mail the Plan and more.

Prescription Drug Benefit Plan – *Administered By:*

EXPRESS SCRIPTS®

Effective July 1, 2006

Express Scripts is the pharmacy benefit manager for your prescription drug benefit plan. If you have any questions about your prescription drug benefits, contact Express Scripts toll free at (877) 828-9744 (TDD: (800) 855-2881).

The following information replaces the second paragraph of text as well as the chart located in the Express Scripts section on page 11 of the 2005 Series 3 benefit update:

One of the ways your plan maintains coverage of quality cost-effective medications is a multi-tier copayment pharmacy benefit. Effective July 1, 2006, copayments for omeprazole (generic Prilosec®) will decrease. Copayments will increase for non-preferred brand name drugs purchased through home delivery (mail order). The following chart illustrates your copayment based on the type of prescription you fill and where you get it filled.

Copayment for:	Participating Retail Pharmacy up to a 30-day supply	Home Delivery (Mail Order) up to a 90-day supply
<u>Tier 1: Generic Drugs</u> All generic drugs <i>except</i> : <ul style="list-style-type: none"> • omeprazole (<i>acid reducer</i>) • Value Tier generics • Also covered: Prilosec OTC® (<i>28-day supply – retail; 84-day supply – mail</i>)*	\$7	\$14
<u>Tier 2: Preferred Brand Name Drugs</u> All preferred brand name drugs <i>and</i> : <ul style="list-style-type: none"> • omeprazole (<i>acid reducer</i>) 	\$20	\$40
<u>Tier 3: Non-Preferred Brand Name Drugs</u> All non-preferred brand name drugs <i>including</i> : <ul style="list-style-type: none"> • COX-2 inhibitors (<i>pain and inflammation – Celebrex®</i>) • Brand name proton pump inhibitors (<i>acid reducers – currently Aciphex®, Nexium®, Prilosec®, Prevacid®, Protonix®</i>) 	\$40	\$90
<u>Value Tier</u> <ul style="list-style-type: none"> • Generic statin (<i>cholesterol lowering – lovastatin</i>) • Generic H-2 antagonists (<i>acid blockers – cimetidine 300, 400 and 800mg; famotidine 40mg; nizatidine 150 and 300mg; ranitidine 300mg</i>) 	\$2	\$4

* Due to manufacturer packaging

United Behavioral Health

Mental Health, Substance Abuse and Enrollee Assistance Programs

Effective July 1, 2006

The following information is provided as a clarification to the information found in your Series 3 Member Handbook. This benefit update is effective as of July 1, 2006.

As a reminder, your Series 3 Member Handbook and benefit update clarifications provide you with a “Description of Benefits” for your mental health, substance abuse and EAP services. While it is a full description of the available benefits under this plan, it is not the “Evidence of Coverage,” the legal policy document that UBH submits to the Massachusetts Division of Insurance (DOI).

The “Evidence of Coverage” governs the plan and includes state and federal mandated language, required disclosures to the Office of Patient Protection, continuation of coverage provisions as directed by state and federal law, and other required plan disclosures. The full “Evidence of Coverage” is available in electronic form and can be downloaded from the UBH website: www.liveandworkwell.com (access code: 10910). If you would prefer a paper copy of this document, please send a written request to UBH at the address provided on page 109 of the Series 3 Member Handbook, and a copy will be sent to you free of charge.

Part II – Benefit Chart: Outpatient Care

The **Outpatient Care** benefits chart on page 115 of the Series 3 Member Handbook is deleted and replaced in its entirety with the summary chart on the following page. Be sure to read Part III (pages 116-121 of the Series 3 Member Handbook), which describes your benefits in detail and notes some important restrictions.

Outpatient Care (a): Covered Service	Network Benefits	Out-of-Network Benefits
First Four Visits	Full Coverage (Medicare Extension OME)	First 15 visits: 80% of <i>allowed charges</i>
Visits 5 and over (Individual)	100%, after \$15 per individual visit, \$10 per group visit (Non-Medicare)	Visits 16 and over: 50% of <i>allowed charges</i> (c)
Visits 5 and over (Group)	100%, after \$10 per visit (Medicare Extension OME) 100%, after \$15 per visit (Non-Medicare)	
Medication Management: 15-30 minute psychiatrist visit	100%, after \$5 per visit (Medicare Extension OME) 100%, after \$10 per visit (Non-Medicare)	
	Network costs paid by member count towards <i>out-of-pocket maximum</i>	Out-of-network care utilized to satisfy the annual deductible counts toward the first 15 visits. Out-of-network costs paid by member do not count toward <i>out-of-pocket maximum</i>
Enrollee Assistance Program	Up to 4 visits: 100% (Medicare Extension OME) Up to 3 visits: 100% (Non-Medicare)	No Coverage for EAP
In-Home Mental Health Care	Full Coverage	First 15 visits: 80% of <i>allowed charges</i> Visits 16 and over: 50% of <i>allowed charges</i> (c)
Drug Testing (as an adjunct to Substance Abuse Testing)	Full Coverage	No Coverage
Provider Eligibility – provider must be an independently licensed mental health professional in one of these disciplines.	MD Psychiatrist, PhD, EdD, MSW, MSN, LICSW, RNMSCS, MA (b)	MD Psychiatrist, PhD, EdD, MSW, MSN, LICSW, RNMSCS, MA (b)

- (a) Treatment that is not *precertified* receives out-of-network reimbursement.
- (b) Massachusetts independently licensed providers; psychiatrists, psychologists, licensed clinical social workers, psychiatric nurse clinical specialists and allied health professionals.
- (c) Out-of-Network outpatient visits 16 and over are subject to the same precertification requirements as Network benefits in order to be eligible for coverage.

Part III – Benefits Explained

The **Outpatient Care** paragraphs in the section titled “Network Benefits” on page 117 of the Series 3 Member Handbook are deleted and replaced with the following:

Network Benefits

Outpatient Care – The *copayment* schedule for network outpatient covered services is shown below:

Non-Medicare

Individual (Non-Medicare), all visits	\$15 <i>copayment</i>
Group therapy (Non-Medicare), all visits	\$10 <i>copayment</i>
Medication Management (Non-Medicare), all visits	\$10 <i>copayment</i>
EAP (Non-Medicare), up to 3 visits	No <i>copayment</i>

Medicare

Visits 1-4 (Medicare OME)	No <i>copayment</i>
Individual (Medicare OME), visits 5 and over	\$10 <i>copayment</i>
Group therapy (Medicare OME), visits 5 and over	\$ 5 <i>copayment</i>
Medication Management (Medicare OME), all visits	\$ 5 <i>copayment</i>
EAP (Medicare OME), up to 4 visits	No <i>copayment</i>

For Non-Medicare-Eligible retirees, outpatient care no longer *cross accumulates* with EAP services (see page 119 of the Series 3 Member Handbook for a full explanation of EAP services). All outpatient mental health and substance abuse services now have a copay.

For Medicare-Eligible retirees, outpatient care *cross accumulates* with EAP services.

Failure to *precertify* outpatient care results in a benefit reduction to the out-of-network benefit level.

*Please note that the **Substance Abuse Rehabilitation Incentive Program** described on page 117 of the Series 3 Member Handbook is no longer available.*

Notice of Group Insurance Commission Privacy Practices

The following information is added to the Series 3 Member Handbook as Appendix F.

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

By law, the GIC must protect the privacy of your personal health information. The GIC retains this type of information because you receive health benefits from the Group Insurance Commission. Under federal law, your health information (known as “protected health information” or “PHI”) includes what health plan you are enrolled in and the type of health plan coverage you have. This notice explains your rights and our legal duties and privacy practices.

The GIC will abide by the terms of this notice. Should our information practices materially change, the GIC reserves the right to change the terms of this notice, and must abide by the terms of the notice currently in effect. Any new notice provisions will affect all protected health information we already maintain, as well as protected health information that we may receive in the future. We will mail revised notices to the address you have supplied, and will post the updated notice on our website at www.mass.gov/gic.

Required and Permitted Uses and Disclosures

We use and disclose protected health information (“PHI”) in a number of ways to carry out our responsibilities. The following describes the types of uses and disclosures of PHI that federal law requires or permits the GIC to make *without* your authorization:

Payment Activities – The GIC may use and share PHI for plan payment activities, such as paying administrative fees for health care, paying health care claims, and determining eligibility for health benefits.

Health Care Operations – The GIC may use and share PHI to operate its programs that include evaluating the quality of health care services you receive, arranging for legal and auditing services (including fraud and abuse detection); and performing analyses to reduce health care costs and improve plan performance.

Other Permitted Uses and Disclosures – The GIC may use and share PHI as follows:

- to resolve complaints or inquiries made on your behalf (such as appeals)
- to verify agency and plan performance (such as audits)
- to communicate with you about your GIC-sponsored benefits (such as your annual benefits statement)
- for judicial and administrative proceedings (such as in response to a court order)
- for research studies that meet all privacy requirements
- to tell you about new or changed benefits and services or health care choices

Required Disclosures – The GIC **must** use and share your PHI when requested by you or someone who has the legal right to act for you (your Personal Representative); when requested by the United States Department of Health and Human Services to make sure your privacy is being protected, and when otherwise required by law.

Organizations that Assist Us – In connection with payment and health care operations, we may share your PHI with our third party “Business Associates” or insurers that perform activities on our behalf, for example, our Indemnity Plan administrator or insurer. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we have asked of them. These business associates will be contractually bound to safeguard the privacy of your PHI.

Except as described above, the GIC will not use or disclose your PHI without your written authorization. You may give us written authorization to use or disclose your PHI to anyone for any purpose. You may revoke your authorization so long as you do so in writing; however, the GIC will not be able to get back your health information we have already used or shared based on your permission.

Your Rights

You have the right to:

- Ask to see and get a copy of your PHI that the GIC maintains. *You must ask for this in writing.* Under certain circumstances, we may deny your request. If the GIC did not create the information you seek, we will refer you to the source (e.g., your health plan administrator). The GIC may charge you to cover certain costs, such as copying and postage.
- Ask the GIC to amend your PHI if you believe that it is wrong or incomplete and the GIC agrees. *You must ask for this in writing, along with a reason for your request.* If the GIC denies your request to amend your PHI, you may file a written statement of disagreement to be included with your information for any future disclosures.
- Get a listing of those with whom the GIC shares your PHI. *You must ask for this in writing.* The list will *not* include health information that was: (1) collected prior to April 14, 2003; (2) given to you or your personal representative; (3) disclosed with your specific permission; (4) disclosed to pay for your health care treatment, payment or operations; or (5) part of a limited data set for research.
- Ask the GIC to restrict certain uses and disclosures of your PHI to carry out payment and health care operations; and disclosures to family members or friends. *You must ask for this in writing.* Please note that the GIC will consider the request, but we are not required to agree to it and in certain cases, federal law does not permit a restriction.
- Ask the GIC to communicate with you using reasonable alternative means or at an alternative address, if contacting you at the address we have on file for you could endanger you. *You must tell us in writing that you are in danger; and where to send communications.*
- Receive a separate paper copy of this notice upon request (an electronic version of this notice is on our web site at www.mass.gov/gic).

If you believe that your privacy rights may have been violated, you have the right to file a complaint with the GIC or the federal government. GIC complaints should be directed to: GIC Privacy Officer, P.O. Box 8747, Boston, MA 02114. Filing a complaint or exercising your rights will not affect your GIC benefits. To file a complaint with the federal government, you may contact the United States Secretary of Health and Human Services. To exercise any of the individual rights described in this notice, or if you need help understanding this notice, please call (617) 727-2310, extension 1 or TTY for the deaf and hard of hearing at (617) 227-8583.

Your Prescription Drug Coverage and Medicare

The following information is added to the Series 3 Member Handbook as Appendix G.

Important Notice About Your Prescription Drug Coverage and Medicare

**The Centers for Medicare Services requires that this
NOTICE OF CREDITABLE COVERAGE be sent to you.
Please read it carefully and keep it where you can find it.**

Starting January 1, 2006, new Medicare prescription drug coverage will be available to everyone with Medicare. This notice:

- applies to you only if you are currently Medicare-eligible or if you should become Medicare-eligible within the coming year;
- provides information about your GIC-sponsored drug coverage and the new Medicare drug coverage to help you decide whether to enroll in one of the Medicare drug plans;
- explains your options; and
- tells you where to find more information to help you make a decision.

**FOR MOST PEOPLE, THE DRUG COVERAGE YOU CURRENTLY HAVE THROUGH YOUR
GIC HEALTH PLAN IS A BETTER VALUE THAN THE NEW MEDICARE DRUG PLANS',
SO YOU DO NOT NEED TO PAY FOR ADDITIONAL DRUG COVERAGE.**

The New Medicare Drug Plans

The new Medicare prescription drug benefit, also known as Medicare Part D, will be offered through various health plans and other organizations. All Medicare prescription drug plans will provide at least the standard level of coverage set by Medicare; some plans might also offer more coverage for a higher monthly premium. In order to decide whether to join a Medicare drug plan, compare which drugs the Medicare drug plans in your area cover and their costs, and consider the following information:

- **You can continue to receive prescription drug coverage through your GIC health plan rather than joining a new Medicare drug plan. Most GIC members do not need to do anything and should not enroll in a Medicare drug plan.**
- Your GIC drug coverage is part of your GIC health insurance, which pays for your health expenses as well as your prescription drugs.
- If you elect Medicare drug coverage, you will have to pay for the entire Medicare drug coverage premium.
- If you should enroll in a Medicare drug plan while you are also enrolled in *Fallon Senior Plan*, *Harvard Pilgrim Health Care First Seniority* or *Tufts Health Plan Medicare Preferred* (formerly *Secure Horizons*), you will lose your GIC-sponsored health plan coverage under current Medicare rules.
- If you have limited income and assets, the Social Security Administration offers help paying for Medicare prescription drug coverage. Help is available on-line at www.socialsecurity.gov, or by phone at (800) 772-1213 (TTY: (800) 325-0778).

Creditable Coverage Information

Your GIC prescription drug coverage is, on average, expected to pay out at least as much as the standard Medicare drug coverage will pay. This means that your GIC coverage is “Creditable Coverage.” You may need to show this notice to the Social Security Administration as proof that you have Creditable Coverage (to avoid paying a premium penalty), if you later enroll in a Medicare drug plan.

If you drop or lose your GIC coverage and do not enroll in a Medicare prescription drug plan soon after your GIC coverage ends, you could be required to pay a premium penalty for Medicare drug coverage when you do enroll. After May 15, 2006, if your GIC coverage ends and you delay 63 days or longer to enroll in Medicare drug coverage, you will have to pay a premium penalty for as long as you have Medicare drug coverage. Your monthly Medicare drug premium will go up at least 1 percent per month for every month after May 15, 2006 that you do not have creditable drug coverage. In addition, you may have to wait until the next Medicare annual enrollment period to enroll.

For more information about this notice or your prescription drug coverage options:

- Call (800) MEDICARE – (800) 633-4227. TTY users should call (877) 486-2048.
- Visit www.medicare.gov.
- Call the Group Insurance Commission at (617) 727-2310.

The Uniformed Services Employment and Reemployment Rights Act (USERRA)

The following information is added to the Series 3 Member Handbook as Appendix H.

The Uniformed Services Employment and Reemployment Rights Act (USERRA)

The Uniformed Services Employment and Reemployment Rights Act (USERRA) protects the rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services. The GIC has more generous guidelines for benefit coverage that apply to persons subject to USERRA, as set forth below:

- If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents.
- If you don't elect to continue coverage during your military service, you have the right to be reinstated to GIC health coverage when you are reemployed.
- Service members who elect to continue their GIC health plan coverage are required to pay the employee share for such coverage.
- USERRA coverage runs concurrently with COBRA and other state continuation coverage.
- The U.S. Department of Labor, Veterans' Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.

For assistance in filing a complaint, or for any other information on USERRA, contact VETS at (866) 4-USA-DOL or visit its web site at www.dol.gov/vets. If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice for representation. You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA. The rights listed here may vary depending on the circumstances.

For more information, please contact the Group Insurance Commission.



**Commonwealth
Indemnity Plan**
Administered by UNICARE

PO Box 9016
Andover, MA 01810-0916

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**Important Information Enclosed
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